Breast and Cervical Cancer Program
APPLICATION ADDENDUM

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows states to provide full Medicaid benefits to individuals who are found to be in need of treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia). This coverage group is known as the Breast and Cervical Cancer Program (BCCP). The following criteria must be met:

- The individual is an adult under age 65;
- The individual must meet SC state residency, citizenship/alienage, and identity requirements;
- The individual does not have other insurance coverage that would cover treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia), including Medicare Part A or B;
- The individual's family income is at or below 200% of the Federal Poverty Level; and
- The individual is not eligible for another Medicaid eligibility group.

Application process

Upon being diagnosed with breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical breast hyperplasia) an individual can apply for coverage in the following manner:

1. Complete and sign the Application for Healthy Connections Medicaid (DHHS Form 3400).
2. The provider rendering the diagnosis must complete and sign Section II on Page 2 below.
3. The completed application and addendums are faxed to the Breast and Cervical Cancer Program at (803) 255-8237. A Pathology Report indicating the diagnosis and a copy of the applicant's insurance card must be faxed with the application. **Note:** A cytology report (Pap Smear) is not sufficient.
4. The applicant will be notified in writing of approval or denial of the application. Individuals who qualify are eligible for the full range of Medicaid coverage.
5. Coverage continues as long as eligibility criteria are met and the beneficiary continues treatment. The beneficiary must report to their Medicaid worker when treatment is completed.
6. Eligibility is reviewed annually for individuals with breast or cervical cancer and bi-annually (every six months) for individuals with pre-cancerous lesions. When it is time for the review, a review form is mailed to the beneficiary and must be returned or coverage will stop.
7. Once treatment is completed, the beneficiary must qualify under another Medicaid program for coverage to continue.

If you have questions regarding the BCCP, or need help in completing this addendum, please call: 1-888-549-0820 (toll-free).

APPLICATION ADDENDUM - Breast and Cervical Cancer Program

Section I – To be completed by Applicant/Beneficiary

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I voluntarily authorize and request disclosure (including written, verbal, and electronic interchange) to DHEC of all my medical records, education records and other information related to my BCCPTA application.

Signature of Applicant/Beneficiary: ***Date:***

Section II-To be completed by the Medical Provider – *Please print.*

Is this a Best Chance Network (BCN) patient? ☐ Yes ☐ No	BCN Screening Provider Site:	Date of BCN Screening:
Provider Referring Patient to Medicaid:	Address:	Telephone: ( ) Fax: ( )
Has the patient been diagnosed and requires treatment for? ☐ Breast Cancer ☐ Cervical Cancer ☐ Atypical Breast Hyperplasia ☐ Precancerous Cervical Lesions (CIN 2/3)		Date of Diagnosis: ***(Attach Pathology Report.)***

Has the patient received treatment for this diagnosis in the past 3 months?	☐ Yes	☐ No
Did the patient have insurance coverage for these expenses?	☐ Yes	☐ No
Is the patient in need of continued treatment?	☐ Yes	☐ No

If yes, please send current office notes

Name of Person Completing the application addendum: ***Telephone ( )*** ***Date:***

Please mail or fax the completed form to:

SCDHHS-Central Mail
P.O. Box 100101
Columbia, SC 29202

Phone #: 803-741-1165
Fax #: 803-255-8237